KAISER PERMANENTE	Patient Name:
	Patient Name: Date of Birth:
Kaiser Foundation Hospitals Permanente Medical Groups	Address:
	City
AUTHORIZATION FOR USE OR DISCLOSURE	State: Zip Code:
OF PATIENT HEALTH INFORMATION	Telephone Number: ( )
Note: Fees may apply to certain requests	Email:
Kaiser Permanente will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization.	
This authorizes the following Kaiser Permanente	Kaiser Permanente may disclose this information to:
Medical Center(s):	Recipient Name:
	Address:
To: 🖵 Produce a copy of medical records as	City:
specified below	State: Zip Code:
Complete form(s) (Please specify form	Telephone number: ()
type(s) in the PURPOSE section below)	Fax number: ()
Allow named KP physician to view records	Email:
PURPOSE: The health information disclosed may only be used for the following purposes:	
FOR COPIES, SPECIFY THE HEALTH INFORMATION	ON NEEDED FOR USE OR DISCLOSURE
Medical Office Records dated from to	
Hospital Records dated from to	
NOTE: Hospital and medical office records ma alcohol/drug, and HIV references. The actual treatm	y include information related to mental health, ent records from mental health and/or alcohol/drug
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 Date
 Signature

 NS-9934 (2-11) HIPAA COMPLIANT SPANISH-NS-1614; CHINESE-NS-6274
 90258 (REV. 2-11) SPANISH 01782-000; CHINESE 01782-002

PARTY CANARY - PATIENT